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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505514		C 02/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND REHABILITATION CENTER	1745 PIKE AVENUE RICHLAND, WA 99352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Richland Rehabilitation Center on 02/25/13 and 02/26/13. A sample of 4 residents was selected from a census of 65. The sample included 3 current residents and the records of 1 former and/or discharged resident. The following complaint was investigated as part of this survey: #2754701 The survey was conducted by: [redacted] RN [redacted] RN The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597 2/27/13 Residential Care Services Date	F 000	**F000 Initial Comments** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Richland Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." **The facility requests an Informal Dispute Resolution.** Received Yakima RCS MAR 14 2013	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314	**F314** **It is the policy of Richland Rehabilitation Center, that based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314	Continued From page 1 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure prevention devices were in place for 1 of 4 residents (#1) in the sample who were identified as high risk for the development of pressure sores. Failure to provide pressure relieving devices for Resident #1 resulted in the development of a Stage II pressure ulcer on her right heel. Findings include: Resident #1. Admitted [redacted]/12 following [redacted] of a [redacted] (upper [redacted]). The initial [redacted] risk assessment, dated 12/29,31/12, noted the resident was a high risk for the development of pressure areas. She had poor safety judgment, impaired mobility, a decrease in her functional range of motion, required a mechanical lift for transfers and had [redacted] (swelling) in both legs and ankles. The plan of care, dated 01/11/13, identified she was at risk for skin impairment with approaches to encourage fluids, encourage and assist her to reposition while in bed as she would not remember to turn due to her [redacted] Staff was	F 314	**they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.** **Resident #1 blister to right heel is resolved and resident has discharged.** **Residents noted to be at high risk for development of pressure ulcers, based on the Braden scale, have the potential to be affected . Residents at high risk will have care plans reviewed to ensure preventive devices are documented and in place, as appropriate.** Director of Nursing Services re-educated nursing staff regarding completion and use of the Braden scale for implementing prevention devices. The re-education was completed on March 13, 2013. Director of Nursing Services re-educated nurses on documenting wounds, as well as staging of pressure ulcers. This re-education was completed on March 13, 2013.	

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F 314	Continued From page 2 to provide incontinent care, a pressure reduction cushion in her wheelchair and a pressure reduction mattress on her bed. Her skin was to be assessed every week and physical therapy was to evaluate her for pressure relief and/or positioning. On 01/16/13 (16 days after admission) progress notes documented the resident had an "intact blister" ([redacted] to her [redacted]. A dressing was applied to the area. The physician was notified the following day with orders to apply a topical antiinfective iodine to the right heel twice daily until it resolved. The facility's "Incident Investigation" of 01/17/13 noted the the resident was unable to move her right extremity "as often" and the shoes she had on were very tight. The investigation concluded that her shoes were not to be worn, "blue boots on in bed," and to encourage repositioning every two hours. The directive for the blue boots ([redacted]) was not added to the plan of care until 02/05/13, 20 days after the development of the [redacted] area. There was no documentation that the "blue boots" were in place for the resident prior to 02/05/13. In addition, the Skin Grid, on which staff documented the appearance of the wound, noted the right heel had an intact blister which was "unstageable". The Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0 defines a [redacted] area as a "partial thickness loss of dermis presenting as a shallow open [redacted] with a red-pink wound bed without slough. May also present as an intact	F 314	Resident Care Managers will audit completion of Braden scale and implementation of prevention devices on a daily basis. Director of Nursing Services/designee will complete random weekly audits to ensure completion of Braden scale, care plan updates, and prevention devices are in use as ordered. Director of Nursing Services/designee will randomly audit skin grids weekly to ensure that wounds are documented correctly by stage if appropriate. Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance. Our date of compliance is March 19, 2013.	

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F 314	Continued From page 3 open/ruptured blister." On 02/26/13 at approximately 10:30 a.m. the Director of Nursing stated the resident should have had the prevention boots on when admitted. In addition, she stated the blister should have been identified as a [redacted] area. On 02/25,26/13 during observations, the resident had the blue heel protector boots in place. Although the facility identified the resident as high risk for developing [redacted], her loss of functional mobility and inability to remember to reposition in bed, pressure relieving devices were not put in place for her heels until after she developed a [redacted] sore on the [redacted] heel.	F 314		